THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF UNEMPLOYMENT ASSISTANCE

THE MEDICAL SECURITY PROGRAM

Health Insurance Benefits for Unemployment Insurance Claimants

Application for Coverage

Your Medical Security Program (MSP) package contains an application, brochure and return envelope. Please read the enclosed brochure for eligibility requirements and health insurance benefits of Premium Assistance Plan versus Direct Coverage Plan.

Depending on your circumstances, you may apply for the Premium Assistance Plan or Direct Coverage Plan. The information requested on this form will be used to document your eligibility for the Medical Security Plan and enrollment in either the Premium Assistance Plan or Direct Coverage Plan.

Steps for completing the application:

1. **Read the brochure carefully before completing the application.**
2. Complete all 3 pages and every section of the form. Make sure all the information is correct. **Missing, incomplete and/or inaccurate information will delay the processing of your application and the date your coverage begins**.
3. **Return your completed application using the enclosed return envelope or mail to MSP Customer Service, P.O. Box 146758, Boston, MA 02114.**
4. If you have any questions about completing this form, or if you need interpreter's assistance, please call MSP Customer Service at 1-800-908-8801. Monday through Friday from 8:30 a.m. to 4:30 p.m.

If you are enrolled in Medicaid or Medicare Part B, you are not eligible for MSP.

If you have any questions about completing this form, or you need it interpreted, call the Medical Security Program customer service unit at 1-800-908-8801 Hours are Monday – Friday 8:30 a.m. to 4:30 p.m.

Если у Вас возникли вопросы в связи с заполнением этой формы или если Вам нужно перевести ее, звоните в отдел медицинского страхования (Medical Security Program или MSP) в отдел обслуживания клиентов по телефону 1-800-908-8801 Мы работаем с понедельника по пятницу с 8:30 утра до 4:30 дня.

Si tiene alguna duda al llenar este formulario o necesita su interpretación al español, llame a la unidad de servicio al cliente del Programa de Seguridad Médico (Medical Security Program) al 1-800-908-8801 de lunes a viernes, de 8:30 a.m. a 4:30 p.m.

Se desidera ricevere ulteriori informazioni sul modo di completare questo modulo o se ha bisogno dei servizi di un interprete, si rivolga all'unità di servizio clienti del Programma di sicurezza sanitaria (Medical Security Program) all'1-800-908-8801 L'orario è dal lunedì al venerdì dalle 8:30 del mattino alle 4:30 del pomeriggio.

Em caso de dúvidas sobre o preenchimento deste formulário, ou se necessitar de explicações adicionais em português, contactar o Serviço de Assistência do Programa de Seguro de Saúde (Medical Security Program) através do telefone 1-800-908-8801 O horário é de segunda a sexta-feira, das 8:30 am às 4:30 pm.

Si ou gen nenpòt kesyon sou kijan pouranpli fòmilè sila, oubyen si ou bezwen yon moun entèprete li ba ou, rele depatman sèvis kliyan pou Pwogram sekirite medikal la nan 1-800-908-8801 Li è ouvèti se lendi a vandredi ant 8:30 am a 4:30 pm.

Nếu có bất cứ thắc mắc nào về việc điền hay cần thông dịch mẫu này, xin gọi đơn vị Dịch Vụ Khách Hàng của Chương Trình An Sinh Y Tế theo số 1-800-908-8801 Giờ làm việc: Thứ Hai đến thứ Sáu, từ 8:30 sáng đến 4:30 chiều.

Please read the accompanying brochure before completing application. Please print clearly.

1. Applicant Information (the person receiving unemployment insurance benefits is the applicant):

☐ Ms. ☐ Mr. ☐ Mrs. Last Name: _____ First Name: _____ Middle Initial _____

Social Security Number: _____-_____-_____ Birth date: _____/_____/_____
Month Day Year

Mailing Address: _____

City: _____ State: MA Zip: _____ Telephone: _____

Please check the boxes that apply to you.

a) Gender: ☐ Female ☐ Male b) Pregnant:* ☐ Yes ☐ No

c) Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated d) Disabled:** ☐ Yes ☐ No

e) Access to Spousal Insurance: ☐ Yes ☐ No If no, please explain in the space provided or attach a written explanation.

_____

_____

f) Are you enrolled in: ☐ Medicare **Part A** ☐ Medicare **Part B** ☐ Medicaid ☐ MassHealth ☐ Commonwealth Care

If you are enrolled in Medicaid or Medicare Part B, you are not eligible for MSP.

2. Plan/Coverage Selection:

MSP has two plans: Premium Assistance and Direct Coverage. The MSP brochure explains the two plans and lists the eligibility requirements for each. Either plan is available for individual or family coverage.

a) Which plan are you applying for? (select one)

☐ **Premium Assistance** – MSP reimburses a portion of your COBRA or self-pay premium (see brochure).
A copy of your COBRA letter from your employer indicating the name of your health plan, COBRA start date and the amount of your premium is required. If you maintained your own health insurance, provide a copy of a bill indicating your monthly premium.

☐ **Direct Coverage** – if you did not have prior insurance provided or the option to continue.

☐ **Direct Coverage with Hardship Waiver** – for people who do not feel able to continue COBRA even with MSP subsidy.
If your family income exceeds the income guideline, provide the following information:
• Continuing health care coverage notification (COBRA letter) from your former employer.
• MSP will assign expenses by family size.

Without this information your request for a Hardship Waiver can not be processed.

If you meet the criteria for a Hardship Waiver, you will be enrolled in the Direct Coverage Plan. If not, you will be enrolled in the Premium Assistance Plan, if qualified. You will be informed of the decision in writing.

b) Which coverage are you applying for? (select one) ☐ Family ☐ Individual

c) Did you have insurance through your most recent employer? ☐ Yes ☐ No
If you answered no, proceed to question 3.

d) Do you have the option to continue the health benefit plan provided through your most recent employer?

☐ Yes ☐ No Date COBRA began _____/_____/_____
Month Day Year

If you do not have the option to continue your employer health plan, reason _____

e) Are you responsible for 100% (all) of your monthly COBRA/self-pay premium? ☐ Yes ☐ No

f) Name of health plan _____ ☐ Family ☐ Individual

g) Monthly premium $ _____

* Proof Required – a copy of a letter from your doctor on letterhead (for premium purposes).
** Proof required – a copy of the determination issued by the Social Security Administration or by Massachusetts Rehabilitation Commission or a copy of the letter from your doctor on letterhead.

3. Family Information:

Please provide the information requested about your current spouse and children (covered up to their 26th birthday or disabled children regardless of age). Fill out completely for each dependent, and if applicable, please submit proof of full-time student status for out-of-state students, pregnancy*, and disability status** with this application.

	Full Name (Last, First, Middle Initial)	**Social Security Number**	**Date of Birth** (Month/Day/Year)	**Sex**	**Pregnant**	**Disabled**	**Is this person a resident of MA?**	**Does this person have other health care coverage? If you answer yes, provide the name of the health plan.**
Spouse				☐M☐F	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
Children				☐M☐F	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
				☐M☐F	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
				☐M☐F	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
				☐M☐F	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
				☐M☐F	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N
				☐M☐F	☐Y☐N	☐Y☐N	☐Y☐N	☐Y☐N

If you are divorced or separated and must cover your spouse, include copy of divorce decree or separation agreement.

4. Applicant's Employer Information:

Provide the information requested for *all* of your employers within the last six months. Include the following to verify your information:

Employer's Name	**Employer's Address**	**Telephone Number**

5. Spouse's Earned Income Information:

Provide the information requested for all of your spouse's employers within the last six months. Include the following to verify your information:

a) A copy of your spouse's last four pay stubs from each employer; or an original letter (no copies) verifying your spouse's wages signed by the employer from each employer.

b) Please note if spouse is collecting unemployment insurance.

c) **If spouse has not worked in the last six months, a letter signed by spouse noting no employment.**

d) **If your spouse is self-employed, include Schedule C of Tax Return or a Profit and Loss statement.**

Employer's Name	**Employer's Address**	**Telephone Number**

6. Spousal Insurance:

a) Name of health plan _____ b) Date available _____/_____/_____
Month Day Year

c) Spouse's current monthly premium $ _____

d) Monthly premium to cover applicant $ _____

A letter on the company's letterhead confirming the above information is required.

* Proof Required – a copy of a letter from your doctor on letterhead (for premium purposes).

** Proof required – a copy of the determination issued by the Social Security Administration or by Massachusetts Rehabilitation Commission or a copy of the letter from your doctor on letterhead.

7. "Other" than employer or unemployment income (Applicant and Spouse):

Please provide information about any significant income (not reported above). "Other" Income may include, but is not limited to child support, severance, paid out sick time and vacation, SSI, rental income, worker's compensation, alimony, dividend and interest distributions, etc.

Source of Income:	Amount Earned in last 6 months	Estimated Earnings next 6 months

8. Important! Signature of Authorization and Certification:

I authorize my health care providers, other health plans, and my former employer to release information from my records to the Department of Unemployment Assistance (DUA) and Network Health, acting as its agent, to:

- Inform the providers of health care service from whom I am seeking health care that I am eligible for this program.
- Release information from my medical records to, and request information from, third parties in order to verify information necessary to determine my eligibility for this program.
- Release information from my records to other governmental agencies as required by statute, regulation, and /or interagency agreement for the purposes of facilitating and reporting MSP services, benefits and costs, ensuring the integrity of the Medical Security Program, and assisting in the transitioning from the Medical Security Program to another health plan.
- Periodic cross matches will be conducted to determine if you or your dependents are/were enrolled in another health plan, including Medicare. As a result, you or your dependents' initial and continued eligibility may be impacted. If you or your dependents are/were enrolled in another program including Medicare you may be responsible for payment for services received.

If I am applying for Direct Coverage, I ASSIGN to DUA the rights to payments for my health care services from any third party insurer to the extent that DUA has paid or is obligated to pay for those health care services for me and/or my dependents.

I hereby certify that I have reviewed all four pages of the application and that I have exercised my best efforts to obtain and truthfully report the information requested. I certify that all the statements made by me in this application are true and complete to the best of my knowledge and belief. I understand that DUA, will rely on the information provided by me in this application in determining my eligibility for MSP and associated benefits.

I understand that knowingly and willfully misrepresenting information provided on this form might subject me to criminal or civil liability under the laws of the Commonwealth of Massachusetts.

Applicant's Signature: _____ Date: ____/____/_____

Printed Name: _____

If you are married and applying for a family membership, both you and your spouse must sign and date this application:

Spouse's Signature: _____ Date: _____/_____/_____

Printed Name: _____

SEND IN AN ENVELOPE TO:
MEDICAL SECURITY PROGRAM
P.O. BOX 146758, BOSTON, MA 02114-0020

For more information on the Medical Security Program, please visit www.mass.gov/dua/msp